2008 Joint Venture Conference

Billing and Reimbursement

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Standardized Billing Guidelines

- Mandated by the National Defense Authorization Act of FY 2003
- MOA for standardized rates and Outpatient Guidance signed in FY 2003
- Inpatient Guidance developed and signed in FY 2006
- Revised Outpatient Guidance is in final stages of completion

MOA on Standardized Rates

- Methodology based on TRICARE/CMAC with 10% discount
- Same for outpatient SCI, TBI and blind rehab. New MOA uses VA interagency rates for inpatient.
- Joint Ventures were allowed extra flexibility to negotiate a greater discount if other sharing arrangements exist.
- Includes a waiver process if the rate does not cover marginal cost or if rate is higher than local market rates

VA Reimbursement Policy Changes

- New VHA Policy Handbook Clarifies Facilities' Guidance
  - Follow VA-DoD Outpatient & Inpatient MOUs by Basing Reimbursement on CMAC/DRGs;
  - No longer necessary to File Disclosure Statements if Agreements are not Based on Full or Direct Costs;
  - IDME Cannot Be Included As a Cost When Developing Agreements

New Outpatient Billing Guidance

- Developing guidance to replace the FY 2003 outpatient billing guidance
- Same methodology, but more explanation
  - CMAC less 10% is basic fee
  - Will use category 1 and 3 “non-facility based provider” which includes small office fee
  - Will use global rates for radiology/laboratory less 10%
  - Physical therapy/occupational therapy global CMAC less 10%

Outpatient Billing, cont.

- Areas we couldn’t standardize:
  - Emergency Room Facility Fee – negotiate locally; same for observation beds
  - Pharmacy – DoD will use average wholesale pricing with no dispensing fee per DoD Uniform Business Office; VA will use cost of medication plus an $8.00 dispensing fee
  - Ambulatory Procedure Visits Institutional Charges: DoD will use rates from Uniform Business Office, VA will use reasonable charges
  - Ambulatory Surgery: same as APVs
  - Dental services: low volume of sharing for dental, no methodology included

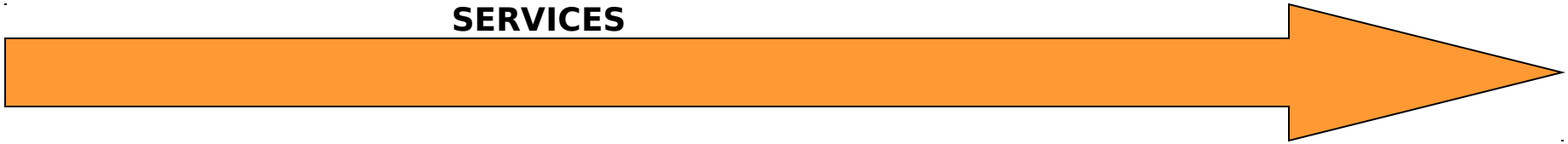
Standardized Reimbursement Rates – When to Use?

- Use for an episode of care; not meant for reimbursement of staff, space or supplies alone.
- Use for laboratory tests when patient presents in the lab; not meant for reference lab arrangements.
- May not apply to certain mental health inpatient care with extreme length of stay.
- Not meant for “sub-acute” status such as long stay ventilator patients

Consider Your Sharing Relationship

The nature of the sharing agreements should guide reimbursement.

BUYER/SELLER RELATIONSHIP	BUYER/SELLER RELATIONSHIP WITH SOME SHARED SERVICES	JOINT VENTURE OR MANY SHARED SERVICES	FULLY INTEGRATED ORGANIZATION



STANDARDIZED RATES	STANDARDIZED RATES BUT MAY NEED WAIVER	STANDARDIZED RATES WITH BIGGER DISCOUNTS OR NEGOTIATED PRICING	FULLY INTEGRATED BUDGET

Waivers

- Certain sites are free to negotiate discounts greater than CMAC less 10% - eight JVs and a few other co-located facilities
  - Considering changes to add more sites
- Other sites can request a waiver to do the same – instructions in the guidance

Future topics for the Financial Management Workgroup

- Bartering
- Cost analysis templates
- Exporting good ideas from financial demonstration projects or elsewhere
- Performance metrics for JIF

QUESTIONS?